House of Representatives

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House Bill No. 5006
As Amended by House
Amendment Schedule "A"

Approved by the Legislative Commissioner
April 14, 2010

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (2) of subsection (b) of section 38a-9 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) The commissioner shall prepare a list of at least ten persons, who have not been employed by the department or an insurance company during the preceding twelve months, to serve as arbitrators in the settlement of such disputes. The arbitrators shall be members of any dispute resolution organization approved by the commissioner. One arbitrator shall be appointed to hear and decide each complaint. Appointment shall be based solely on the order of the list. If an arbitrator is unable to serve on a given day, or if either party objects to the arbitrator, then the next arbitrator on the list **[**will**]** <u>shall</u> be selected. The department shall schedule arbitration hearings as often, and in such locations, as it deems necessary. Parties to the dispute shall be provided written notice of the hearing **[**,**]** at least ten days prior to the

hearing date. The commissioner may issue subpoenas on behalf of the arbitrator to compel the attendance of witnesses and the production of documents, papers and records relevant to the dispute. Decisions shall be made on the basis of the evidence presented at the arbitration hearing. Where the arbitrator believes that technical expertise is necessary to decide a case, **[**he**]** such arbitrator may consult with an independent expert recommended by the commissioner. The arbitrator and any independent technical expert shall be paid by the department on a per dispute basis as established by the commissioner. The arbitrator, as expeditiously as possible **[**,**]** but not later than fifteen days after the arbitration hearing, shall render a written decision based on the information gathered and disclose the findings and the reasons to the parties involved. The arbitrator shall award filing fees to the prevailing party. If the decision favors the consumer the decision shall provide specific and appropriate remedies including interest at the rate of ten per cent on the arbitration award concerning the disputed amount of the claim, retroactive to the date of payment for the undisputed amount of the claim. The decision may include costs for loss of use and storage of the motor vehicle and shall specify a date for performance and completion of all awarded remedies. Notwithstanding any provision of the general statutes or any regulation, **[**to the contrary,**]** the Insurance Department shall not amend, reverse, rescind, or revoke any decision or action of any arbitrator. The department shall contact the consumer **[**within**]** not later than ten **[**working**]** business days after the date for performance, to determine whether performance has occurred. Either party may make application to the superior court for the judicial district in which one of the parties resides or, when the court is not in session, any judge thereof for an order confirming, vacating, modifying or correcting any award, in accordance with the provisions of sections 52-417, 52-418, 52-419 and 52-420. If it is determined by the court that either party's position after review has been improved by at least ten per cent over that party's position after arbitration, the court **[**, in its discretion,**]** may grant to that party its costs and reasonable attorney's fees. No evidence, testimony, findings, or decision from the department

arbitration procedure shall be admissible in any civil proceeding, except judicial review of the arbitrator's decision as contemplated by this subsection.

Sec. 2. Subdivision (15) of subsection (a) of section 38a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(15) (A) Captive insurers, as defined in section 38a-91k, as amended by this act, and (B) captive insurance companies, as defined in section 38a-91aa, if a registered agent cannot be found with reasonable diligence at the registered office of a captive insurance company.

Sec. 3. Subdivision (3) of subsection (b) of section 38a-55 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) In the case of a domestic life insurance company, the provisions of this subsection shall apply to a separate account only to the extent that reserves for guarantees with respect to (A) benefits guaranteed as to dollar amount and duration or (B) funds guaranteed as to principal amount or stated rate of interest are held in a separate account in accordance with subdivision **[**(iii)**]** (3) of subsection (a) of section 38a-433, as amended by this act.

Sec. 4. Subsection (c) of section 38a-60 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) If such emergency plan is adopted, it may provide that it will become operative automatically during any such national emergency and, notwithstanding any **[**contrary**]** provision of the law or the charter or bylaws of the company, may contain any provisions reasonably necessary for the operation of the company during any such national emergency. Such provisions need not be consistent with the comparable provisions stated in subsection (b) of this section. Such provisions may provide, among other things, for (1) the designation of

persons who may call a meeting of the board of directors; (2) the quorum and notice requirements for, and location of, any such meeting; (3) the filling of vacancies on the board of directors; (4) a succession list of persons by name or title who will succeed to positions of higher rank; (5) the establishment of the principal office of the company at a new location in or out of the state.

Sec. 5. Subsection (d) of section 38a-91ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) In the case of a captive insurance company:

(1) **[**(A)**]** Formed as a corporation, before the articles of incorporation are transmitted to the Secretary of the State, the incorporators shall petition the Insurance Commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed corporation will promote the general good of the state. In arriving at such a finding the commissioner shall consider:

[(i)**]** (A) The character, reputation, financial standing and purposes of the incorporators;

[(ii)**]** (B) The character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors; and

[(iii)**]** (C) Such other aspects as the commissioner deems advisable.

[(B) The articles of incorporation, such certificate and the organization fee shall be transmitted to the Secretary of the State who shall record both the articles of incorporation and the certificate.**]**

(2) Formed as a reciprocal insurer, the organizers shall petition the commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed association will promote the general good of the state. In arriving at

such a finding the commissioner shall consider the items set forth in **[**subparagraph (A) of**]** subdivision (1) of this subsection.

(3) Formed as a limited liability company, before the articles of organization are transmitted to the Secretary of the State, the organizers shall petition the commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed company will promote the general good of the state. In arriving at such a finding, the commissioner shall consider the items set forth in **[**subparagraph (A) of**]** subdivision (1) of this subsection.

(4) The articles of incorporation and certificate set forth in subdivisions (1) to (3), inclusive, of this subsection shall be transmitted to the Secretary of the State along with any fees required by the Secretary of the State, who shall record both the articles of incorporation and the certificate.

Sec. 6. Section 38a-91k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each captive insurer that is domiciled in another state and offers, renews or continues insurance in this state shall provide the information described in subdivisions (1) to (3), inclusive, of subsection (a) of section 38a-253 to the Insurance Commissioner in the same manner required for risk retention groups. If a captive insurer does not maintain information in the form prescribed in section 38a-253, the captive insurer may submit the information to the Insurance Commissioner on such form as the commissioner prescribes. As used in this section and section 38a-25, as amended by this act, "captive insurer" means an insurance company owned by another organization whose primary purpose is to insure risks of a parent organization or affiliated persons, as defined in section 38a-1, or in the case of groups and associations, an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations and group members and their affiliates.

Sec. 7. Subsection (d) of section 38a-102 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) In the case of a domestic life insurance company, the investment limitations set forth in section 38a-102c shall apply to a separate account only to the extent that reserves for guarantees with respect to (1) benefits guaranteed as to dollar amount and duration or (2) funds guaranteed as to principal amount or stated rate of interest are held in a separate account in accordance with subdivision (3) of subsection (a) **[**(iii)**]** of section 38a-433, as amended by this act.

Sec. 8. Section 38a-307a of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

From July 1, 2004, until the expiration of the Terrorism Insurance Program established in the federal Terrorism Risk Insurance Act of 2002, P.L. 107-297, as amended from time to time, **[**for**]** (1) for any master policy that is required to be purchased by a condominium association pursuant to section 47-83 or by a unit owners' association pursuant to section 47-255, the standard form of fire insurance policy set forth in section 38a-307, as amended by this act, shall not exclude coverage for loss by fire or other perils insured against in the policy caused, directly or indirectly, by terrorism, as defined by the Insurance Commissioner; and (2) for any other commercial risk insurance policy, the standard form of fire insurance policy set forth in section 38a-307, as amended by this act, may provide that the company shall not be liable for loss by fire or other perils insured against in the policy caused, directly or indirectly, by terrorism, as defined by the Insurance Commissioner, provided the premiums charged for such policy shall reflect any savings projected from the exclusion of such perils.

Sec. 9. Subdivision (2) of subsection (a) of section 38a-336 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) Notwithstanding any provision of this section, [to the contrary,] each automobile liability insurance policy issued or renewed on and after January 1, 1994, shall provide uninsured and underinsured motorist coverage with limits for bodily injury and death equal to those purchased to protect against loss resulting from the liability imposed by law unless any named insured requests in writing a lesser amount, but not less than the limits specified in subsection (a) of section 14-112. Such written request shall apply to all subsequent renewals of coverage and to all policies or endorsements [which] that extend, change, supersede or replace an existing policy issued to the named insured, unless changed in writing by any named insured. No such written request for a lesser amount shall be effective unless any named insured has signed an informed consent form [which] that shall contain: (A) An explanation of uninsured and underinsured motorist insurance approved by the commissioner; (B) a list of uninsured and underinsured motorist coverage options available from the insurer; and (C) the premium cost for each of the coverage options available from the insurer. Such informed consent form shall contain a heading in twelve-point type and shall state: "WHEN YOU SIGN THIS FORM, YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE AGENT OR ANOTHER QUALIFIED ADVISER."

Sec. 10. Section 38a-352 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

All claims paid by an insurer, a holding company of an insurer or a wholly owned subsidiary of an insurer for any loss to a motor [vehicles] vehicle or any claim for damages to a motor [vehicles] vehicle, shall be paid to the claimant by check, electronic transfer to the claimant or other means that provide the claimant immediate access to the funds.

Sec. 11. Subsection (a) of section 38a-433 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A domestic life insurance company, including for the purposes of this section all domestic fraternal benefit societies which operate on a legal reserve basis, may establish one or more separate accounts and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or life or period-certain annuities, and benefits incidental thereto, payable in fixed or variable amounts or both, or to accumulate funds which are paid to or held by such company pursuant to section 38a-459, subject to the following: **[**(i)**]** (1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the company; **[**(ii)**]** (2) except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subdivision **[**(iii) hereof**]** (3) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested in any class of loans and investments, and such loans and investments shall not be included in applying the limitations provided in sections 38a-102 to 38a-102h, inclusive, as amended by this act; **[**(iii)**]** (3) except with the approval of the commissioner and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for **[**(1)**]** (A) benefits guaranteed as to dollar amount and duration, and **[**(2)**]** (B) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account; **[**(iv)**]** (4) unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided, that unless otherwise approved by the commissioner, the portion, if any, of the assets of such separate

account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subdivision [(iii) hereof] (3) of this subsection, shall be valued in accordance with the rules otherwise applicable to the company's assets; [(v)] (5) amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If, and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct; [(vi)] (6) no sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made [(1)] (A) by a transfer of cash, or [(2)] (B) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable; [(vii)] (7) to the extent such company deems it necessary to comply with any applicable federal or state laws, such company, with respect to any separate account, including without limitation any separate account which is a management investment account or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct or the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account. The provisions of this subsection shall apply

notwithstanding any inconsistent provision in the charter of any such domestic life insurance company or in the general statutes.

Sec. 12. Subsection (e) of section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) The provisions of this subsection shall apply to all policies issued on or after the compliance date established by subdivision (11) of this subsection. (1) Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of: (A) The then present value of the future guaranteed benefits provided for by the policy; (B) one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) one hundred twenty-five per cent of the nonforfeiture net level premium as hereinafter defined, provided that in applying the percentage specified in this subparagraph, **[**(C),**]** no nonforfeiture net level premium shall be deemed to exceed four per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined; (2) the nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits divided by the present value, at such date of issue, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium becomes due; (3) in the case of policies **[**which**]** that, on a basis

guaranteed in the policy, provide for unscheduled changes in benefits or premiums, or **[**which**]** that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change; (4) except as otherwise provided in subdivision (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be the uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of: (i) The then present value of the future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy; (5) the additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (A) one per cent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (B) one hundred twenty-five per cent of the increase, if positive, in the nonforfeiture net level premium; (6) the recalculated nonforfeiture net level premium shall be equal to the amount obtained by dividing (A)

by (B) where (A) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change, multiplied by the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium would have become due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium becomes due; (7) notwithstanding any other provisions of this subsection, in the case of a policy issued on a substandard basis **[**which**]** that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis **[**which**]** that provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis; (8) all adjusted premiums and present values referred to in this section shall be calculated: (A) (i) For all policies of ordinary insurance on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table or at the election of the company, for any one or more specified plans of life insurance, on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, or (ii) **[**On**]** on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium; or (iii) **[**For**]** for all policies issued on or after January 1, 2009, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table; (B) for all policies of industrial insurance, on the basis of the Commissioners' 1961 Standard Industrial Mortality Table; (C) for all policies issued in a particular calendar year, on the basis of a rate of interest not exceeding

the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year, provided, that: (i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year; (ii) under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any; (iii) a company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values; (iv) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners' 1961 Industrial Extended Term Insurance Table for policies of industrial insurance; (v) for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables; (vi) any ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner, in accordance with the provisions of chapter 54, for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1980 Standard Ordinary Mortality Table with or without ten-year select mortality factors or the Commissioners' 1980 Extended Term Insurance Table; (vii) any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner, in accordance with the provisions of chapter 54, **[**by the commissioner**]** for use in

determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1961 Standard Industrial Mortality Table or the Commissioners' 1961 Industrial Extended Term Insurance Table; (9) the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five per cent of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, rounded to the nearest one quarter of one per cent; (10) notwithstanding any provision of the general statutes, [to the contrary,] any refiling of nonforfeiture values or their methods of computation for any previously approved policy form [which] that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of [that] such policy form; (11) on or after October 1, 1981, but prior to January 1, 1989, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date and the provisions of this subsection shall apply to such company on or after such specified date, except that on or after January 1, 2005, but prior to January 1, 2009, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date with respect to the Commissioners' 2001 Standard Ordinary Mortality Table and the provisions of this subsection shall apply to such company. The provisions of this subsection shall apply to policies issued by any company on or after January 1, 1989, except that the provisions of this subsection with respect to the Commissioners' 2001 Standard Ordinary Mortality Table shall apply to policies issued by any company on or after January 1, 2009.

Sec. 13. Section 38a-465a of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Except as otherwise provided in this part, no person shall act as a provider or broker until the person is licensed by the commissioner pursuant to this section.

(b) Any applicant for a license as a provider or broker shall submit written application to the commissioner. Such applicants shall provide such information as the commissioner requires. All initial applications shall be accompanied by a filing fee specified in section 38a-11.

(c) A life insurance producer, who has been duly licensed as a resident insurance producer with a life line of authority in this state or in such producer's home state for not less than one year and is licensed as a nonresident producer pursuant to section 38a-702g, shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a broker.

(d) Not later than thirty days after the first day of operating as a broker, a life insurance producer shall notify the commissioner that such producer is acting as a broker on a form prescribed by the commissioner, and shall pay a filing fee as specified in section 38a-11. Such notification shall include an acknowledgement by the life insurance producer that such producer shall operate as a broker in accordance with this part.

(e) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a broker, provider or purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a life settlement contract from the broker, provider or purchaser in connection with such life settlement contract.

(f) A person licensed as an attorney, certified public accountant or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate life settlement contracts on behalf of the owner without being required to obtain a license as a broker.

(g) Any license issued for a provider or broker shall be in force only until the last day of March in each year, but may be renewed by the commissioner without formality other than proper application. The

fees for such licenses shall be assessed annually, as provided in section 38a-11. If such provider or broker fails to timely pay the renewal fee, such license shall be automatically revoked if the license fee is not received by the commissioner not later than the fifth day after the commissioner sends, by first class mail, a written notice of nonrenewal to the principal office of the provider or broker, provided such notice shall only be mailed after said last day of March.

[(h) The term of a provider license shall be equal to that of a domestic stock life insurance company and the term of a broker license shall be equal to that of an insurance producer license. Licenses requiring periodic renewal shall be renewed on their anniversary date upon payment of the renewal fee, as specified in subsection (b) of this section. Failure to pay the fees on or before the renewal date shall result in expiration of the license.**]**

[(i)**]** (h) Upon the filing of an application and full payment of the license fee, the commissioner shall investigate the applicant and shall issue a license if the commissioner determines that:

(1) The applicant, if a provider, has provided a detailed plan of operation;

(2) The applicant is competent and trustworthy, and intends to act in good faith pursuant to the license applied for;

(3) The applicant has a good business reputation and adequate experience, training or education so as to be qualified in the business for which the license is applied;

(4) If the applicant is a corporation, partnership, limited liability company or other legal entity, the applicant is formed or organized pursuant to the laws of this state or is a foreign legal entity authorized to do business in this state, or provides a certificate of good standing from its state of domicile; and

(5) The applicant has provided to the commissioner an antifraud

plan that meets the requirements of subsection (i) of section 38a-465j and includes:

(A) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting fraudulent insurance acts to the commissioner;

(C) A description of the plan for antifraud education and training of its underwriters and other personnel; and

(D) A written description or chart outlining the arrangement of the antifraud personnel responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

[(j)**]** (i) The applicant shall provide to the commissioner such information as the commissioner may require, on forms approved by the commissioner. The commissioner may, at any time, require the applicant to fully disclose the identity of its stockholders, except stockholders owning less than ten per cent of the shares of an applicant whose shares are publicly traded, partners, officers and employees, and the commissioner may deny any application for a license if the commissioner determines that any partner, officer, employee or stockholder thereof who may materially influence the applicant's conduct fails to meet any of the standards set forth in sections 38a-465 to 38a-465q, inclusive.

[(k)**]** (j) A license issued to a corporation, partnership, limited liability company or other legal entity authorizes all of such legal entity's members, officers and designated employees named in the application for such license, and any supplements to the application, to act as a licensee under such license.

[(l)**]** (k) The commissioner shall not issue any license to any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

[(m)**]** (l) Each licensee shall file with the commissioner on or before the first day of March of each year an annual statement containing such information as the commissioner may prescribe by regulation.

[(n)**]** (m) A provider shall not use any person to perform the functions of a broker, as defined in this part, unless such person holds a current, valid license as a broker and as provided in this section.

[(o)**]** (n) A broker shall not use any person to perform the functions of a provider, as defined in this part, unless such person holds a current, valid license as a provider and as provided in this section.

[(p)**]** (o) A provider or broker shall provide to the commissioner new or revised information about officers, stockholders holding ten per cent or more of the company's stock, partners, directors, members or designated employees not later than thirty days after the change in information.

[(q)**]** (p) An individual licensed as a broker shall complete, on a biennial basis, fifteen hours of training related to life settlements and life settlement transactions, except that a life insurance producer operating as a broker pursuant to this section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the commissioner.

Sec. 14. Subsection (a) of section 38a-465c of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No person shall use any form of life settlement contract or disclosure statement in this state unless such form has been filed with and approved by the commissioner. The commissioner shall disapprove a life settlement contract form or disclosure statement form if the commissioner finds any provision in **[**said**]** such form is unreasonable, contrary to the interests of the public, fails to comply with the provisions of sections 38a-465f, 38a-465g, as amended by this act, and 38a-465n and subsection (b) of section 38a-465k, or is otherwise misleading or unfair to the owner. The commissioner may require the submission of advertising materials.

Sec. 15. Section 38a-465g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Before entering into a life settlement contract with any owner of a policy wherein the insured is terminally ill or chronically ill, a provider shall obtain:

(1) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into the settlement contract; and

(2) A document in which the insured consents to the release of the insured's medical records to a provider, broker or insurance producer, and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a provider, broker or life insurance producer on a form approved by the commissioner not later than thirty calendar days after the date the request was received. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation regarding the validity of the policy.

(c) Prior to or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract, that the owner has a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness or condition and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(d) If a broker or life insurance producer performs any of the activities required of the provider under this section, the provider shall be deemed to have fulfilled the requirements of this section.

[(e) If a broker performs the verification of coverage activities required of the provider, the provider shall be deemed to have fulfilled the requirements of subsection (a) of section 38a-465f.**]**

[(f)**]** (e) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

[(g)**]** (f) Not later than twenty days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued the policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by **[**the documents set forth in subsection (c) of section 38a-465h**]** a copy of the medical records release required under subdivision (2) of subsection (a) of this section and a copy of the insured's application for the life settlement contract.

[(h)**]** (g) All medical information solicited or obtained by any person licensed pursuant to this part shall be subject to applicable provisions of law relating to the confidentiality of medical information.

[(i)**]** (h) Each life settlement contract entered into in this state shall

provide that the owner may rescind the contract not later than fifteen days from the date it is executed by all parties thereto. Such rescission exercised by the owner shall be effective only if both notice of rescission is given to the provider and the owner repays all proceeds and any premiums, loans and loan interest paid by the provider within the rescission period. A failure to provide written notice of the right of rescission shall toll the period of such right until thirty days after the written notice of the right of rescission has been given. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the provider.

[(j)**]** (i) Not later than three business days after the date the provider receives the documents from the owner to effect the transfer of the insurance policy, the provider shall pay or transfer the proceeds of the settlement into an escrow or trust account managed by a trustee or escrow agent in a state or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. Not later than three business days after receiving acknowledgment of the transfer of the insurance policy from the issuer of the policy, said trustee or escrow agent shall pay the settlement proceeds to the owner.

[(k)**]** (j) Failure to tender the life settlement contract proceeds to the owner within the time set forth in section 38a-465f shall render the viatical settlement contract voidable by the owner for lack of consideration until the time such consideration is tendered to, and accepted by, the owner.

[(l)**]** (k) Any fee paid by a provider, party, individual or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained and not as a percentage of the face value of the policy. Nothing in this section shall be construed to prohibit a broker from reducing such broker's fee below such percentage.

[(m)**]** (l) Each broker shall disclose to the owner anything of value paid or given to such broker in connection with a life settlement contract concerning the owner.

[(n)**]** (m) No person at **[**anytime**]** any time prior to, or at the time of, the application for or issuance of a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest or surrender of the policy is to occur. This prohibition shall not apply if the owner certifies to the provider that:

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is not less than twenty-four months. The time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

(2) The owner submits independent evidence to the provider that one or more of the following conditions have been met within said two-year period: (A) The owner or insured is terminally ill or chronically ill; (B) the owner or insured disposes of the owner or insured's ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued; (C) the owner's spouse dies; (D) the owner divorces his or her spouse; (E) the owner retires from full-time employment; (F) the owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or (G) a final order, judgment or decree is entered by a court of competent jurisdiction on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee or liquidator to all or a substantial part of the owner's assets.

[(o)**]** (n) Copies of the independent evidence required by subdivision (2) of subsection **[**(n)**]** (m) of this section shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. Nothing in this section shall prohibit an insurer from exercising its right to contest the validity of any policy.

[(p)**]** (o) If, at the time the provider submits a request to the insurer to effect the transfer of the policy to the provider, the provider submits a copy of independent evidence of subparagraph (A) of subdivision (2) of subsection **[**(n)**]** (m) of this section, such copy shall be deemed to establish that the settlement contract satisfies the requirements of this section.

Sec. 16. Subdivision (1) of subsection (a) of section 38a-478c of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F)

notwithstanding the provisions of this subsection, on or before July [1, 1998, and annually thereafter] first of each year, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

Sec. 17. Subsection (b) of section 38a-479rr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) (1) A current and accurate list of authorized marketers, specified in subparagraph (M) of subdivision (2) of subsection (a) of this section, shall be submitted to the commissioner with each renewal fee, as set forth in subsection (c) of this section.

(2) Any change made to the list of authorized marketers, specified in subparagraph (M) of subdivision (2) of subsection (a) of this section, shall be electronically filed with the commissioner. If such change is to add a marketer to a medical discount plan organization's list of authorized marketers, such change shall be electronically filed by such organization prior to the marketer doing business in the state for such organization.

(3) The commissioner may adopt regulations, in accordance with chapter 54, to establish the procedure and format of the electronic filing [and acknowledgment] set forth in this subsection.

Sec. 18. Subsection (b) of section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from*

passage):

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to **[**insure**]** ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

Sec. 19. Subdivision (6) of subsection (b) of section 38a-483 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) A provision as follows: "RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred

dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time." The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty, or (2) **[**,**]** in the case of a policy issued after age forty-four, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

Sec. 20. Section 38a-491a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall provide coverage for general anesthesia, nursing and related hospital services provided in conjunction with in-patient, outpatient or one-day dental services if the following conditions are met:

(1) The anesthesia, nursing and related hospital services are deemed medically necessary by the treating dentist or oral surgeon and the patient's primary care physician in accordance with the health insurance policy's requirements for prior authorization of services; and

(2) The patient is either (A) determined by a licensed dentist, in conjunction with a licensed physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (B) a person who has a developmental disability, as determined by a licensed physician who specializes in primary care, that places the person at serious risk.

(b) The expense of such anesthesia, nursing and related hospital services shall be deemed a medical expense under such health insurance policy and shall not be subject to any limits on dental benefits under such policy.

Sec. 21. Section 38a-492j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2000,**]** that provides coverage for ostomy surgery shall include coverage, up to one thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

Sec. 22. Subsection (f) of section 38a-495a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) Notwithstanding any other provision of law, **[**to the contrary,**]** a Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective

date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

Sec. 23. Subsection (a) of section 38a-500 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Notwithstanding any other provision of the general statutes, **[**to the contrary,**]** no individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, **[**or**]** renewed **[**on or after October 1, 1984,**]** or continued in this state may exclude coverage for a bodily injury solely because it was caused by an accident arising out of and in the course of employment to a covered individual who is: (1) A sole proprietor or business partner who is not covered by the provisions of chapter 568 or who accepts the provisions of chapter 568 pursuant to subdivision (10) of section 31-275; or (2) an employee of a corporation and who is a corporate officer, regardless of any election by such individual to be excluded from coverage under chapter 568 pursuant to subparagraph (B)(v) of subdivision (9) of section 31-275. **[**The provisions of this section shall also apply to all such policies or contracts in this state as of the first anniversary date of such policy or contract on or after October 1, 1984.**]** The payment of benefits pursuant to this section shall be subject to any policy or contract provisions **[**which**]** that apply to a claim not resulting from bodily injury caused by an accident arising out of and in the course of employment.

Sec. 24. Section 38a-504 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society

[which] that delivers, [or] issues for delivery, renews, amends or continues in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469, shall provide coverage under such policies for the surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedure in connection with the treatment of tumors, and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 25. Subsection (c) of section 38a-511 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section **[**38a-520**]** 38a-493.

Sec. 26. Section 38a-513e of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) In the event (1) an employer, as defined in section 31-58, terminates an employee for any reason other than layoff or relocation or closing of a covered establishment, as defined in section 31-51n, or (2) an employee voluntarily terminates employment with an employer, such employer may elect not to pay the premium for such employee and any such employee's dependents under a group health insurance policy after the date of such employee's termination. In the event such employer makes such election, any insurer, health care center, hospital or medical service corporation or fraternal benefit society that issues such group health insurance policy shall credit such employer the amount of any premium paid by such employer with respect to such policy for such employee and such employee's dependents attributable to the period after the date of such employee's termination, provided the employer notifies the insurer, health care center, hospital or medical service corporation or fraternal benefit society that issued such policy and the terminated employee not later than seventy-two hours after the termination. Upon the issuance or renewal of such policy, such insurer, health care center, hospital or medical service corporation or fraternal benefit society shall provide such employer with relevant information related to such employer's election, including a notice that it is the employer's responsibility to remit to the terminated employee such employee's portion of the credited premium. Any such credit shall be applied to the employer's next month's premium. In the event of nonrenewal of such policy, the insurer, health care center, hospital or medical service corporation or

fraternal benefit society shall refund such credit to the employer.

(b) Notwithstanding the provisions of subsection (a) of this section, (1) any contractual agreement entered into through collective bargaining that requires the employer to pay the premium for an employee under a group health insurance policy after the date of such employee's termination shall supersede the provisions of subsection (a) of this section, and (2) no credit shall be available to an employer for any employee's and employee's dependents' coverage for the seventy-two hours immediately following the termination of such employee.

(c) Any right of an employee and his dependents to continuation of coverage following the relocation or closing of a covered establishment, as set forth in section 31-51o, shall not be affected by the provisions of this section.

Sec. 27. Subsection (a) of section 38a-517a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2000,**]** shall provide coverage for general anesthesia, nursing and related hospital services provided in conjunction with in-patient, outpatient or one-day dental services if the following conditions are met:

(1) The anesthesia, nursing and related hospital services are deemed medically necessary by the treating dentist or oral surgeon and the patient's primary care physician in accordance with the health insurance policy's requirements for prior authorization of services; and

(2) The patient is either (A) determined by a licensed dentist, in conjunction with a licensed physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (B)

a person who has a developmental disability, as determined by a licensed physician who specializes in primary care, that places the person at serious risk.

Sec. 28. Section 38a-518j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 2000,**]** that provides coverage for ostomy surgery shall include coverage, up to one thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

Sec. 29. Subsection (a) of section 38a-527 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Notwithstanding any other provision of the general statutes, **[**to the contrary,**]** no group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, **[**or**]** renewed **[**on or after October 1, 1984,**]** or continued in this state may exclude coverage for a bodily injury solely because it was caused by an accident arising out of and in the course of employment to a covered individual who is: (1) A sole proprietor or business partner who is not covered by the provisions of chapter 568 or who accepts the provisions of said chapter 568 pursuant to subdivision (6) of section 31-275; or (2) an employee of a corporation and who is a corporate officer, regardless of any election by such individual to be excluded from coverage under

said chapter 568 pursuant to subparagraph (E) of subdivision (5) of section 31-275. **[**The provisions of this section shall also apply to all such policies in this state as of the first anniversary date of such policy on or after October 1, 1984.**]** The payment of benefits pursuant to this section shall be subject to any policy provisions **[**which**]** that apply to a claim not resulting from bodily injury caused by an accident arising out of and in the course of employment.

Sec. 30. Section 38a-538 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each employer shall allow individuals to elect to continue coverage under a group plan pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time.

Sec. 31. Section 38a-542 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society **[**which**]** that delivers, **[**or**]** issues for delivery, renews, amends or continues in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage under such policies for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, and costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary. Such benefits shall be subject to

the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of one thousand dollars for the costs of removal of any breast implant, five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 32. Subsection (a) of section 38a-546 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, each group health insurance policy, regardless of the number of insureds, providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 1997,**]** shall, subject to the provisions of subsection (d), contain those provisions described in subsections (b) and (d) of section 38a-554.

Sec. 33. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38a-551, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under **[**subdivision**]** subsection (a) of this section, and shall exercise its powers through a board of directors established under this section.

(a) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. (2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under sections 38a-505, 38a-546,

as amended by this act, and 38a-551 to 38a-559, inclusive, must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an **[**administering carrier**]** administrator and set forth the powers and duties of the **[**administering carrier**]** administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; (H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive; (I) contain additional provisions necessary for the association to qualify as an acceptable alternative mechanism in accordance with Section 2744 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191)**]** P.L. 104-

191; and (J) contain additional provisions necessary for the association to qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002, **[**(P.L. 107-210)**]** P.L. 107-210. The commissioner may adopt regulations in accordance with the provisions of chapter 54, to establish criteria for the association to qualify as an acceptable alternative mechanism.

(b) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; (3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association; (4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association; (5) administer any type of reinsurance program, for or on behalf of participating members; (6) pool risks among participating members; (7) issue policies of insurance on an indemnity or provision of service basis providing the coverage required by sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive, in its own name or on behalf of participating members; (8) administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members; (9) operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association; (10) set limits on the amounts of reinsurance **[**which**]** that may be ceded to the association by its members; (11) appoint from among

participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association; and (12) apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, private firms, individuals and foundations for the purpose of carrying out its responsibilities. Any such funds received shall be deposited in the General Fund and shall be credited to a separate nonlapsing account within the General Fund for the Health Reinsurance Association and may be used by the Health Reinsurance Association in the performance of its duties.

(c) Every member shall participate in the association in accordance with the provisions of this **[**subdivision**]** subsection. (1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks: (A) Individual, excluding group conversion; and (B) individual, including group conversion. (2) No member shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks **[**which**]** that are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association. (3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply, but rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by

insurers for groups of ten lives, provided incurred losses [which] that result from provision of coverage in accordance with section 38a-537 shall not be considered. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent or more than one hundred fifty per cent of the average rate charged for that classification with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate or unfairly discriminatory.

(d) (1) Following the close of each fiscal year, the [administering carrier] administrator shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums. (2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board. (3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public

accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38a-14. (4) For the fiscal year ending December 31, 1993, and the first quarter of the fiscal year ending December 31, 1994, the **[**administering carrier**]** administrator shall not include health care centers in assessing any net losses to participating members.

(e) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state. Coverage provided to a HIPAA or health care tax credit eligible individual may be terminated to the extent permitted by HIPAA or the Trade Act of 2002, respectively.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of

section 38a-557 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under sections 38a-505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care plan.

Sec. 34. Subdivisions (3) and (4) of section 38a-564 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis. "Eligible employee" shall include any employee who is not actively at work but is covered under the small employer's health insurance plan pursuant to (A) workers' compensation, (B) continuation of benefits pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time, **[**(COBRA)**]** or (C) other applicable laws. **[**Such employees shall not be counted as eligible employees for the purposes of subsection (4) of this section.**]**

(4) (A) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual. **[**In**]** For the purposes of determining the number of eligible employees **[**,

companies which**]** under this subdivision: (i) Companies that are affiliated companies, as defined in section 33-840, or **[**which**]** that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer; **[**. Eligible employees shall not include**]** (ii) employees covered through the employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act shall not be counted; and (iii) employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time, or other applicable laws shall not be counted. Except as otherwise specifically provided, provisions of sections 12-201, 12-211, 12-212a and 38a-564 to 38a-572, inclusive, as amended by this act, that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(B) "Small employer" does not include (i) a municipality procuring health insurance pursuant to section 5-259, (ii) a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, or (v) a community action agency procuring health insurance pursuant to section 5-259.

Sec. 35. Section 38a-569 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) There is established a nonprofit entity to be known as the "Connecticut Small Employer Health Reinsurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after July 1, 1990, shall be members of the pool.

(2) On or before July 15, 1990, the commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meeting, which shall take place by September 1, 1990. The members shall select the initial board, subject to approval by the commissioner. The board shall consist of at least five and not more than nine representatives of members. There shall be no more than two members of the board representing any one insurer or insurance arrangement. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be weighted based upon net health insurance premium derived from this state in the previous calendar year. To the extent possible, at least one-third of the members of the board shall be domestic insurance companies and at least two-thirds of the members of the board shall be small employer carriers. At least one member of the board shall be a health care center and at least one member shall be a small employer carrier with less than one hundred million dollars in net small employer health insurance premium in this state. The Insurance Commissioner shall be an ex-officio member of the board. The net premium amount shall be adjusted by the board periodically for health care cost inflation. In approving selection of the board, the commissioner shall assure that all members are fairly represented. The membership of all boards subsequent to the initial board shall, to the extent possible, reflect the same distribution of representation as is described in this subdivision.

(3) If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen days of the organizational meeting.

(4) Within ninety days after the appointment of such initial board,

the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided he determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (d) of this section. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments, as appropriate. The commissioner shall amend any plan adopted by him, as necessary, at the time a plan of operation is submitted by the board and approved by the commissioner.

(5) The plan of operation shall establish procedures for: (A) Handling and accounting of assets and moneys of the pool, and for an annual fiscal reporting to the commissioner; (B) filling vacancies on the board, subject to the approval of the commissioner; (C) selecting an **[**administering insurer**]** administrator and setting forth the powers and duties of the **[**administering insurer**]** administrator; (D) reinsuring risks in accordance with the provisions of this section; (E) collecting assessments from all members to provide for claims reinsured by the pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and (F) any additional matters at the discretion of the board.

(6) The pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance and, in addition thereto, the specific authority to: (A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the

authority, with the approval of the commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions; (B) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members; (C) take such legal action as necessary to avoid the payment of improper claims against the pool; (D) define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this section; (E) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the pool; (F) establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the pool; (G) assess members in accordance with the provisions of subsection (e) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; (H) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool; and (I) borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(b) Any member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, except that no member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, whose premium rates are not subject to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any reinsurance placed with the pool from the date of the establishment of the pool regarding the coverage of an eligible employee of a small employer, or

any dependent of such an employee shall be provided as follows:

(1) (A) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; (B) with respect to other plans, the pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health care plan or the actuarial equivalent thereof as defined and authorized by the board; and (C) in either case, no reinsurance may be provided in any calendar year for a reinsured employee or dependent until five thousand dollars in benefit payments have been made for services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of the annual five-thousand-dollar deductible. The amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board;

(2) With respect to eligible employees, and their dependents, coverage may be reinsured: (A) Within such period of time after the commencement of their coverage under the plan as may be authorized by the board, or (B) commencing January 1, 1992, on the first plan anniversary after the employer's coverage has been in effect with the small employer carrier for a period of three years, and every third plan anniversary thereafter, provided, commencing May 1, 1994, reinsurance pursuant to this subparagraph shall only be permitted with respect to eligible employees and their dependents of a small employer which has no more than two eligible employees as of the applicable anniversary;

(3) Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary;

(4) Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth; and

(5) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection: (A) Coverage for eligible employees and their dependents provided under a group policy covering two or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering two or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and (B) at the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

(c) Except as provided in subsection (d) of this section, premium rates charged for reinsurance by the pool shall be established at the following percentages of the rate established by the pool for that classification or group with similar characteristics and coverage:

(1) One hundred fifty per cent, with respect to all of the eligible employees, and their dependents, of a small employer, all of whose coverage is reinsured in accordance with subdivision (2) of subsection (b) of this section; and

(2) Five hundred per cent, with respect to an eligible employee or dependent who is individually reinsured in accordance with subdivision (2) of subsection (b) of this section and is not reinsured with all eligible employees of an employer and their dependents.

(d) Premium rates charged for reinsurance by the pool to a health care center which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300 et seq., and as such is subject to requirements that limit the amount of risk that may be ceded to the pool, may be modified by the board, if appropriate, to reflect the portion of risk that may be ceded to the pool.

(e) (1) Following the close of each fiscal year, the **[**administering insurer**]** administrator shall determine the net premiums, the pool

expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health insurance premiums earned by insurance arrangements shall be established by adding paid health losses and administrative expenses of the insurance arrangement. Health insurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health insurance premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped by assessments of members. (A) Assessments shall first be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from health insurance plans and insurance arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the pool, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operations. An assessment shall be made pursuant to this subparagraph against a health care center, which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300e et seq., subject to an assessment adjustment formula adopted by the board and approved by the commissioner for such health care centers which recognizes the restrictions imposed on such health care centers by federal law. Such adjustment formula shall be adopted by the board and approved by the commissioner prior to the first anniversary of the pool's operation. (B) If such net loss is not recouped before assessments totaling five per cent of such premiums from plans and arrangements covering small employers have been collected, additional assessments shall be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive of any individual Medicare supplement policies as defined in section 38a-495 during such calendar

year. (C) Notwithstanding the provisions of this subdivision, the assessments to any one member under subparagraph (A) or (B) of this subdivision shall not exceed forty per cent of the total assessment under each subparagraph for the first fiscal year of the pool's operation and fifty per cent of the total assessment under each subparagraph for the second fiscal year. Any amounts abated pursuant to this subparagraph shall be assessed against the other members in a manner consistent with the basis for assessments set forth in this subdivision.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Insurance arrangements shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The board may defer, in whole or in part, the assessment of a health care center if, in the opinion of the board: (A) Payment of the assessment would endanger the ability of the health care center to fulfill its contractual obligations, or (B) in accordance with standards included in the plan of operation, the health care center has written, and reinsured in their entirety, a disproportionate number of special health care plans. In the event an assessment against a health care center is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The health care center receiving such deferment shall

remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

(f) (1) Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this section shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

(2) Any person or member made a party to any action, suit **[**,**]** or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The Insurance Commissioner may retain actuarial consultants necessary to carry out **[**his**]** said commissioner's responsibilities pursuant to sections 38a-564 to 38a-572, inclusive, as amended by this act, and such expenses shall be paid by the pool established in this section.

Sec. 36. Subdivision (7) of section 38a-760a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Reinsurance intermediary-manager" means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as a

reinsurance intermediary-manager, manager or other similar term. Notwithstanding any provision [to the contrary] of the general statutes, the following persons shall not be considered a reinsurance intermediary-manager, with respect to such reinsurer, for the purposes of sections 38a-760 to 38a-760i, inclusive: (A) An employee of the reinsurer; (B) a United States manager of the United States branch of an alien reinsurer; (C) an underwriting manager [which] that, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to sections 38a-129 to 38a-140, inclusive, and whose compensation is not based on the volume of premiums written; (D) the manager of a group, association, pool or organization of insurers [which] that engages in joint underwriting or joint reinsurance and [who are] that is subject to examination by the insurance commissioner of the state in which the manager's principal business office is located;

Sec. 37. Subdivision (2) of subsection (d) of section 38a-790 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) "Motor vehicle physical damage appraiser" means any person, partnership, association, limited liability company or corporation [which] that practices as a business the appraising of damages to motor vehicles insured under automobile physical damage policies or on behalf of third party claimants.

Sec. 38. Section 38a-839 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

There is created a nonprofit unincorporated legal entity to be known as the Connecticut Insurance Guaranty Association. All insurers defined as member insurers in subdivision (8) of section 38a-838 shall be members of said association as a condition of their authority to transact insurance in this state. Said association shall perform its functions under a plan of operation established and approved under section 38a-842, as amended by this act, and shall exercise its powers

through a board of directors established under section 38a-840, as amended by this act. For the purposes of administration and assessment, said association shall be divided into three separate accounts: [(a)] (1) The workers' compensation insurance account; [(b)] (2) the automobile insurance account; and [(c)] (3) an account for all other insurance to which sections 38a-836 to 38a-853, inclusive, apply.

Sec. 39. Section 38a-840 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(1)] (a) The board of directors of said association shall consist of not less than five nor more than nine persons serving terms as established in the plan of operation under section 38a-842, as amended by this act. The members of the board of directors shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining members, subject to the approval of the commissioner. If no members are selected within sixty days after October 1, 1971, the commissioner may appoint the initial members of the board of directors.

[(2)] (b) In approving selections to said board, the commissioner shall consider among other things whether all member insurers are fairly represented.

[(3)] (c) Members of said board shall receive no compensation as such but shall be reimbursed from the assets of said association for actual and necessary expenses incurred by them in carrying out their official duties as members of the board of directors.

Sec. 40. Section 38a-841 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(1)] (a) Said association shall: [(a)] (1) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the

determination, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of such determination, provided such obligation shall be limited as follows: [(i)] (A) With respect to covered claims for unearned premiums, to one-half of the unearned premium on any policy, subject to a maximum of two thousand dollars per policy; [(ii)] (B) with respect to covered claims other than for unearned premiums, such obligation shall include only that amount of each such claim which is in excess of one hundred dollars and is less than three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, and four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007, except that said association shall pay the full amount of any such claim arising out of a workers' compensation policy, provided in no event shall [(A) said association be obligated] said association be obligated (i) to any claimant in an amount in excess of the obligation of the insolvent insurer under the policy form or coverage from which the claim arises, or [(B) said association be obligated] (ii) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c; [(b)] (2) be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent; [(c)] (3) allocate claims paid and expenses incurred among the three accounts, created by section 38a-839, as amended by this act, separately, and assess member insurers separately [(i)] (A) in respect of each such account for such amounts as shall be necessary to pay the obligations of said association under subdivision [(a)] (1) of subsection [(1)] (a) of this section subsequent to an insolvency; [(ii)] (B) the expenses of handling covered claims subsequent to an insolvency; [(iii)] (C) the cost of examinations under section 38a-846; and [(iv)] (D) such other expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The assessments of each member insurer shall be in the proportion that

the net direct written premiums of such member insurer for the calendar year preceding the assessment on the kinds of insurance in such account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in such account. Each member insurer shall be notified of its assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two per cent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in said account, provided if, at the time an assessment is levied on the "all other insurance" account, as defined in subdivision **[**(c)**]** (3) of section 38a-839, as amended by this act, the board of directors finds that at least fifty per cent of the total net direct written premiums of a member insurer and all its affiliates, for the year on which such assessment is based, were from policies issued or delivered in Connecticut, on risks located in this state, such member insurer shall be assessed only on such member insurer's net direct written premium that is attributable to the kind of insurance that gives rise to each covered claim. If the maximum assessment, together with the other assets of said association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. Said association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance provided that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below the minimum amounts required for a certificate of authority. Such payments shall be refunded to those insurers receiving greater assessments because of such deferment or, at the election of the insurer, be credited against future

assessments. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account in respect of which the assessment is made; **[**(d)**]** (4) investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations, and deny all other claims. The association shall pay claims in any order it deems reasonable, including but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested; **[**(e)**]** (5) notify such persons as the commissioner may direct under subdivision **[**(a)**]** (1) of subsection **[**(2)**]** (b) of section 38a-843, as amended by this act; **[**(f)**]** (6) handle claims through its employees or through one or more insurers or other persons designated by said association as servicing facilities, provided such designation of a servicing facility shall be subject to the approval of the commissioner, and may be declined by a member insurer; **[**(g)**]** (7) reimburse each such servicing facility for obligations of said association paid by such facility and for expenses incurred by such facility while handling claims on behalf of said association and shall pay such other expenses of said association as are authorized by sections 38a-836 to 38a-853, inclusive.

[(2)**]** (b) Said association may: **[**(a)**]** (1) Employ or retain such persons as are necessary to handle claims and perform other duties of said association; **[**(b)**]** (2) borrow such funds as may be necessary from time to time to effect the purposes of sections 38a-836 to 38a-853, inclusive, in accord with the plan of operation under section 38a-842, as amended by this act; **[**(c)**]** (3) sue or be sued; **[**(d)**]** (4) intervene as a matter of right as a party in any proceeding before any court in this state that has jurisdiction over an insolvent insurer, as defined in section 38a-838; **[**(e)**]** (5) negotiate and become a party to such contracts as are necessary to carry out the purpose of said sections; **[**(f)**]** (6)

perform such other acts as are necessary or proper to effectuate the purpose of said sections; [(g)] (7) refund to the member insurers in proportion to the contribution of each such member insurer to that account, that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of said association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

[(3) (A)] (c) (1) Each insurer paying an assessment under sections 38a-836 to 38a-853, inclusive, may offset one hundred per cent of the amount of such assessment against its premium tax liability to this state under chapter 207. Such offset shall be taken over a period of the five successive tax years following the year of payment of the assessment, at the rate of twenty per cent per year of the assessment paid to the association. Each insurer to which has been refunded by the association, pursuant to [subdivision (2)] subsection (b) of this section, all or a portion of an assessment previously paid to the association by the insurer shall be required to pay to the Department of Revenue Services an amount equal to the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns, as the case may be, filed by such insurer and that is attributable to such refunded assessment, provided the amount required to be paid to said department shall not exceed the amount of the refunded assessment. If the amount of the refunded assessment exceeds the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such insurer and that is attributable to such refunded assessment, such excess may not be claimed as an offset against the premiums tax liability on a premiums tax return or returns filed by such insurer or, if the offset has been transferred to another person pursuant to [subparagraph (B)] subdivision (2) of this [subdivision] subsection, by such other person. For purposes of this subparagraph, if the offset has been transferred to another person pursuant to [subparagraph (B)] subdivision (2) of this [subdivision] subsection, the total amount that

has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such insurer includes the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such other person. The association shall promptly notify the Commissioner of Revenue Services of the name and address of the insurers to which such refunds have been made, the amount of such refunds and the date on which such refunds were mailed to such insurer. If the amount that an insurer is required to pay to the Department of Revenue Services has not been so paid on or before the forty-fifth day after the date of mailing of such refunds, the insurer shall be liable for interest on such amount at the rate of one per cent per month or fraction thereof from such forty-fifth day to the date of payment.

[(B)**]** (2) An insurer, in this subparagraph called "the transferor", may transfer any offset provided under **[**subparagraph (A)**]** subdivision (1) of this **[**subdivision**]** subsection to an affiliate, as defined in section 38a-1, of the transferor. Any such transfer of the offset by the transferor and any subsequent transfer or transfers of the same offset shall not affect the obligation of the transferor to pay to the Department of Revenue Services any sums which are acquired by refund from the association pursuant to **[**subdivision (2)**]** subsection (b) of this section and which are required to be paid to the Department of Revenue Services pursuant to **[**subparagraph (A)**]** subdivision (1) of this **[**subdivision**]** subsection. Such offset may be taken by any transferee only against the transferee's premium tax liability to this state under chapter 207. The Commissioner of Revenue Services shall not allow such offset to a transferee against its premium tax liability unless the transferor, the affiliate to which the offset was originally transferred, each subsequent transferor and each subsequent transferee have filed such information as may be required on forms provided by said commissioner with respect to any such transfer or transfers on or before the due date of the premium tax return on which such offset would have been taken by the transferor if no transfer had been made by the transferor.

Sec. 41. Section 38a-842 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(1)**]** (a) (1) Said association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of said association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

[(b)**]** (2) If said association fails to submit a suitable plan of operation within ninety days following October 1, 1971, or if at any time thereafter said association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable regulations as are necessary or advisable to effectuate the provisions of sections 38a-836 to 38a-853, inclusive. Such regulations shall continue in force until modified by the commissioner or superseded by a plan submitted by said association and approved by the commissioner.

[(2)**]** (b) All member insurers shall comply with the plan of operation.

[(3)**]** (c) The plan of operation shall: **[**(a)**]** (1) Establish the procedures whereby all the powers and duties of said association under section 38a-841, as amended by this act, shall be performed; **[**(b)**]** (2) establish procedures for handling the assets of said association; **[**(c)**]** (3) establish the number, the terms of office and the amount and method of reimbursing members of the board of directors under section 38a-840, as amended by this act; **[**(d)**]** (4) establish procedures by which claims may be filed with said association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to said association or its agent and a list of such claims shall be periodically submitted to said association or similar organization having a like function to that of said association in another state by the receiver or liquidator; **[**(e)**]** (5) establish regular places and times for meetings of the board of

directors; [(f)] (6) establish procedures for records to be kept of all financial transactions of said association, its agents, and the board of directors; [(g)] (7) provide that any member insurer aggrieved by any final action or decision of said association may appeal to the commissioner within thirty days after such action or decision; [(h)] (8) establish the procedures whereby selections for the board of directors shall be submitted to the commissioner; [(i)] (9) contain such additional provisions as may be necessary or proper for the execution of the powers and duties of said association under sections 38a-836 to 38a-853, inclusive.

[(4)] (d) The plan of operation may delegate any or all powers and duties of said association, except those under subdivision [(c)] (3) of subsection [(1)] (a) of section 38a-841, as amended by this act, and subdivision [(b)] (2) of subsection [(2)] (b) of section 38a-841, as amended by this act, to a corporation, association, or other organization which performs or will perform functions similar to those of said association, or its equivalent having a like function to that of said association, in two or more states. Such a corporation, association or organization shall be reimbursed by said association as a servicing facility would be reimbursed and shall be paid by said association for its performance of any other functions of said association. Any delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 38a-836 to 38a-853, inclusive.

Sec. 42. Section 38a-843 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(1)] (a) The commissioner shall: [(a)] (1) Notify said association of the existence of an insolvent insurer, and notify the chairman of the Workers' Compensation Commission and the State Treasurer of the existence of an insolvent workers' compensation insurer, not later than three days after he receives notice of the determination of any such

insolvency; [(b)] (2) upon request of the board of directors, provide said association with a statement of the net direct written premiums of each member insurer.

[(2)] (b) The commissioner may: [(a)] (1) Require that said association notify those persons insured by the insolvent insurer, and any other interested parties, of the determination of insolvency and of their rights under sections 38a-836 to 38a-853, inclusive. Such notification shall be by mail sent to their last known address, where available, provided if sufficient information for such notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient to satisfy the requirements of this subsection; [(b)] (2) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or which fails to comply with said plan of operation. In lieu of such suspension or revocation, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due, provided no such fine shall exceed five per cent of the unpaid assessment per month, and provided no fine shall be less than five hundred dollars per month; [(c)] (3) revoke the designation of any servicing facility if [he] the commissioner finds claims are being handled unsatisfactorily.

[(3)] (c) Any person aggrieved by any final action or order of the commissioner under sections 38a-836 to 38a-853, inclusive, may, [within] not later than thirty days from the date of such action or order, petition the superior court for the judicial district of Hartford to require the commissioner to show cause why said action or order should not be reversed or eliminated, and, if said court finds that the action or order of the commissioner was arbitrary and unjustified it shall take such action in the premises as may seem equitable. The pendency of any such petitions to show cause shall act as a stay of execution of any such order. Petitions under this section shall be privileged in respect of trial assignment.

Sec. 43. Section 38a-844 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective from passage*):

[(1)**]** (a) Any person recovering any moneys under sections 38a-836 to 38a-853, inclusive, shall be deemed to have assigned his rights under the policy to said association to the extent of his recovery from said association. Every insured or claimant seeking the protection of said sections shall cooperate with said association to the same extent as such person would have been required to cooperate with the insolvent insurer. Said association shall have no cause of action against any insured of the insolvent insurer for any sums it has paid out to such insured except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of said association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

[(2)**]** (b) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under sections 38a-836 to 38a-853, inclusive, and by settlements of claims made by said association or any similar organization having a like function to that of said association in another state. The court having jurisdiction shall grant such claims priority equal to that to which the claimant would have been entitled in the absence of said sections 38a-836 to 38a-853, inclusive, against the assets of the insolvent insurer. The expenses of said association or any similar organization having a like function to that of said association in handling claims shall be accorded the same priority as the receiver's or liquidator's expenses.

[(3)**]** (c) Said association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by said association, the expenses paid for the processing of covered claims paid or contested and estimates of anticipated claims on said association, and expenses of processing such claims which shall preserve the rights of said association against the assets of the

insolvent insurer.

[(4) (A)**]** (d) (1) Except as provided in **[**subparagraph (B)**]** subdivision (2) of this **[**subdivision**]** subsection, the association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such person pursuant to sections 38a-836 to 38a-853, inclusive: **[**(i)**]** (A) Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and **[**(ii)**]** (B) any insured whose net worth on December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer exceeds fifty million dollars and whose liability obligations to other persons are satisfied in whole or in part by payments made under said sections. For purposes of this subdivision, "insured" does not include a municipality, as defined in section 7-148, or the Second Injury Fund, established in section 31-354.

[(B)**]** (2) The association shall have no right to recover pursuant to **[**subparagraph (A)**]** subdivision (1) of this **[**subdivision**]** subsection from any nonprofit corporation organized to deliver health services and social services to meet the needs of the elderly, that is incorporated in this state and qualified as a Section 501(c)(3) organization under the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, for any amount of covered claims paid on behalf of such corporation on or after December 1, 2001, provided the insolvent insurer was declared insolvent prior to May 27, 2008. Any amounts recovered by the association prior to May 27, 2008, from any such nonprofit corporation or affiliate of such nonprofit corporation shall not be required to be reimbursed to such nonprofit corporation or affiliate of such nonprofit corporation.

Sec. 44. Section 38a-845 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(1)**]** (a) Any person having a claim against an insurer under any

provision in an insurance policy, other than a policy of an insolvent insurer, which is also a covered claim under sections 38a-836 to 38a-853, inclusive, shall exhaust first his rights under such policy. Any amount payable on a covered claim under said sections shall be reduced by the amount recoverable under the claimant's insurance policy or chapter 568.

[(2)**]** (b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent having a like function to that of said association shall seek recovery first from the association operating in the area of the residence of the insured except that **[**(A)**]** (1) if it is a first party claim for damage to property with a permanent location, such person shall seek recovery first from the association operating in the location of the property, and **[**(B)**]** (2) if it is a workers' compensation claim, such person shall seek recovery first from the association operating in the area of residence of the claimant. Any recovery under sections 38a-836 to 38a-853, inclusive, shall be reduced by the amount recoverable from any other insurance guaranty association or its equivalent having a like function to that of said association.

[(3)**]** (c) Any person having a claim under any governmental insurance or guaranty program which such claim is also a covered claim shall be required to first exhaust his rights under such program. Any amount payable on a covered claim under sections 38a-836 to 38a-853, inclusive, shall be reduced by any amount recoverable under such program.

Sec. 45. Subsection (a) of section 38a-916 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and notwithstanding any **[**contrary**]** provision of law, including chapters 55a and 67, the

commissioner may employ such counsel, clerks and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. The commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants or other creditors including guaranty associations should such a committee be deemed necessary, except that the decision to appoint an advisory committee shall be at the sole discretion of the commissioner, and the committee shall serve at the pleasure of the commissioner and shall serve without compensation and without reimbursement for expenses. No other committee of any nature shall be appointed by the commissioner or the court in rehabilitation proceedings conducted under sections 38a-903 to 38a-961, inclusive.

Sec. 46. Subsection (a) of section 38a-923 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The liquidator shall have the power: (1) To appoint a special deputy to act for **[**him**]** such liquidator under sections 38a-903 to 38a-961, inclusive, and to determine **[**his**]** such special deputy's reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator; (2) to employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as **[**he**]** the liquidator may deem necessary to assist in the liquidation, notwithstanding any **[**contrary**]** provision of law, including chapters 55a and 67; (3) to fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court; (4) to pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of,

conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. The liquidator shall have the power to pay reasonable compensation to such persons on an interim basis. All such interim payments shall be subject to the approval of the court upon submission by the liquidator. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the Insurance Department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the Insurance Department out of the first available moneys of the insurer; (5) to hold hearings, to subpoena witnesses, to compel their attendance, to administer oaths, to examine any person under oath and to compel any person to subscribe to **[**his**]** such person's testimony after it has been correctly reduced to writing, and in connection therewith to require the production of any books, papers, records or other documents which **[**he**]** the liquidator deems relevant to the inquiry; (6) to collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose (A) to institute timely action in other jurisdictions in order to forestall garnishment and attachment proceedings against such debts; (B) to do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as **[**he**]** the liquidator deems best; and (C) to pursue any creditor's remedies available to enforce the creditor's claims; (7) to conduct public and private sales of the property of the insurer; (8) to use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 38a-944; (9) to acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. The liquidator shall also have power to execute, acknowledge and deliver any and all deeds,

assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation; (10) to borrow money on the security of the assets in the insurer's estate or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in class 1 under the priority of distributions; (11) to enter into such contracts as are necessary to carry out the order to liquidate and to affirm or disavow any contracts to which the insurer is a party; (12) to continue to prosecute and to institute in the name of the insurer or in the liquidator's own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims **[**he**]** the liquidator deems unprofitable to pursue further. If the insurer is dissolved pursuant to section 38a-922, the liquidator shall have the power to apply to any court in this state or elsewhere for leave to substitute the liquidator for the insurer as plaintiff; (13) to prosecute any action which may exist on behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer or any other person; (14) to remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations; (15) to deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions; (16) to invest all sums not currently needed, unless the court orders otherwise; (17) to file any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located; (18) to assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty

association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations; (19) to exercise and enforce all the rights, remedies **[**,**]** and powers of any creditor, shareholder, policyholder **[**,**]** or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included **[**with**]** under sections 38a-928 to 38a-930, inclusive; (20) to intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and to act as the receiver or trustee whenever the appointment is offered; (21) to enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states; (22) to exercise all powers conferred upon receivers by the laws of this state not inconsistent with the provisions of sections 38a-903 to 38a-961, inclusive; (23) to appoint, with the approval of the court, an advisory committee of policyholders, claimants or other creditors including guaranty associations should such a committee be deemed necessary. The committee shall serve at the pleasure of the commissioner and the decision to appoint an advisory committee shall be at the sole discretion of the commissioner. The committee shall serve without compensation and without reimbursement for expenses. No other committee shall be appointed by the commissioner or the court in liquidation proceedings conducted under sections 38a-903 to 38a-961, inclusive; and (24) to audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

Sec. 47. Section 38a-962h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Notwithstanding any other provision of law, **[**to the contrary,**]** the commissioner may meet with a supervisor appointed under sections 38a-129, 38a-140 and 38a-962 to 38a-962j, inclusive, and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceeding or during

the pendency of any proceeding held under authority of said sections to carry out the commissioner's duties under said sections or for the supervisor to carry out his duties under said sections.

Sec. 48. Section 14-64 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The commissioner may suspend or revoke the license or licenses of any licensee or impose a civil penalty of not more than one thousand dollars for each violation on any licensee or both, when, after notice and hearing, the commissioner finds that the licensee (1) has violated any provision of any statute or regulation of any state or any federal statute or regulation pertaining to its business as a licensee or has failed to comply with the terms of a final decision and order of any state department or federal agency concerning any such provision; or (2) has failed to maintain such records of transactions concerning the purchase, sale or repair of motor vehicles or major component parts, as required by such regulations as shall be adopted by the commissioner, for a period of two years after such purchase, sale or repairs, provided the records shall include the vehicle identification number and the name and address of the person from whom each vehicle or part was purchased and to whom each vehicle or part was sold, if a sale occurred; or (3) has failed to allow inspection of such records by the commissioner or the commissioner's representative during normal business hours, provided written notice stating the purpose of the inspection is furnished to the licensee, or has failed to allow inspection of such records by any representative of the Division of State Police within the Department of Public Safety or any organized local police department, which inspection may include examination of the premises to determine the accuracy of such records; or (4) has made a false statement as to the condition, prior ownership or prior use of any motor vehicle sold, exchanged, transferred, offered for sale or repaired if the licensee knew or should have known that such statement was false; or (5) is not qualified to conduct the licensed business, applying the standards of section 14-51 and the applicable regulations; or (6) has violated any provision of sections 42-221 to 42-226, inclusive; or (7) has

failed to fully execute or provide the buyer with (A) an order as described in section 14-62, (B) the properly assigned certificate of title, or (C) a temporary transfer or new issue of registration; or (8) has failed to deliver a motor vehicle free and clear of all liens, unless written notification is given to the buyer stating such motor vehicle shall be purchased subject to a lien; or (9) has violated any provision of sections 14-65f to 14-65j, inclusive, and section 14-65*l*; or (10) has used registration number plates issued by the commissioner, in violation of the provisions and standards set forth in sections 14-59 and 14-60 and the applicable regulations; or (11) has failed to secure or to account for or surrender to the commissioner on demand official registration plates or any other official materials in its custody. In addition to, or in lieu of, the imposition of any other penalties authorized by this section, the commissioner may order any such licensee to make restitution to any aggrieved customer.

Sec. 49. Subsection (a) of section 14-65g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A customer may waive his right to the estimate of the costs of parts and labor required by section 14-65f, only in writing in accordance with this section. Such a waiver shall include an authorization to perform reasonable and necessary repairs to remedy the problems complained of, at a cost not to exceed a fixed dollar amount. The waiver shall be signed by the customer and the customer shall be given a fully completed copy of the waiver at the time it is signed. No repair shop shall use waivers to evade its duties under sections 14-65e to 14-65j, inclusive, and section 14-65*l*.

Sec. 50. Section 14-65k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Motor Vehicles may conduct investigations and hold hearings on any matter under the provisions of sections 14-51 to 14-65j, inclusive, and section 14-65*l*. The

commissioner may issue subpoenas, administer oaths, compel testimony and order the production of books, records and documents. If any person refuses to appear, to testify or to produce any book, record, paper or document when so ordered, upon application of the commissioner, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement of this section.

(b) The Attorney General, at the request of the commissioner, is authorized to apply in the name of the state of Connecticut to the Superior Court for an order temporarily or permanently restraining and enjoining any person from violating any provision of sections 14-51 to 14-65j, inclusive, and section 14-65*l*.

Sec. 51. Section 20-327b of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Except as otherwise provided in this section, each person who offers residential property in the state for sale, exchange or for lease with option to buy, shall provide a written residential condition report to the prospective purchaser at any time prior to the prospective purchaser's execution of any binder, contract to purchase, option **[**,**]** or lease containing a purchase option. A photocopy, duplicate original, facsimile transmission **[**,**]** or other exact reproduction or duplicate of the written residential condition report containing the prospective purchaser's written receipt shall be attached to any written offer, binder or contract to purchase. A photocopy, duplicate original, facsimile transmission or other exact reproduction or duplicate of the written residential condition report containing the signatures of both seller and purchaser **[**,**]** shall be attached to any agreement to purchase the property.

(b) The following shall be exempt from the provisions of this section: (1) Any transfer from one or more co-owners solely to one or more of the co-owners; (2) transfers made to the spouse, mother, father, brother, sister, child, grandparent or grandchild of the

transferor where no consideration is paid; (3) transfers pursuant to an order of the court; (4) transfers of newly-constructed residential real property for which an implied warranty is provided under chapter 827; (5) transfers made by executors, administrators, trustees or conservators; (6) transfers by the federal government, any political subdivision thereof or any corporation, institution or quasi-governmental agency chartered by the federal government; (7) transfers by deed in lieu of foreclosure; (8) transfers by the state of Connecticut or any political subdivision thereof; (9) transfers of property which was the subject of a contract or option entered into prior to January 1, 1996; and (10) any transfer of property acquired by a judgment of strict foreclosure or by foreclosure by sale or by a deed in lieu of foreclosure.

(c) The provisions of this section shall apply only to transfers by sale, exchange or lease with option to buy, of residential real property consisting of not less than one nor more than four dwelling units which shall include cooperatives and condominiums, and shall apply to all transfers, with or without the assistance of a licensed real estate broker or salesperson, as defined in section 20-311.

(d) (1) Not later than April 1, 2010, the Commissioner of Consumer Protection **[**,**]** shall, by regulations adopted in accordance with the provisions of chapter 54, prescribe the form of the written residential disclosure report required by this section and sections 20-327c to 20-327e, inclusive. The regulations shall provide that the form include information concerning:

(A) Municipal assessments, including, but not limited to, sewer or water charges applicable to the property. Such information shall include: (i) Whether such assessment is in effect and the amount of the assessment; (ii) whether there is an assessment on the property that has not been paid, and if so, the amount of the unpaid assessment; and (iii) to the extent of the seller's knowledge, whether there is reason to believe that the municipality may impose an assessment in the future;

(B) Leased items on the premises, including, but not limited to, propane fuel tanks, water heaters, major appliances and alarm systems; and

(C) (i) Whether the real property is located in a municipally designated village district or municipally designated historic district or has been designated on the National Register of Historic Places, and (ii) a statement that information concerning village districts and historic districts may be obtained from the municipality's village or historic district commission, if applicable.

(2) Such form of the written residential disclosure report shall contain the following:

(A) A certification by the seller in the following form:

"To the extent of the seller's knowledge as a property owner, the seller acknowledges that the information contained above is true and accurate for those areas of the property listed. In the event a real estate broker or salesperson is utilized, the seller authorizes the brokers or salespersons to provide the above information to prospective buyers, selling agents or buyers' agents.

T1 .... (Date) .... (Seller)
T2 .... (Date) .... (Seller)"

(B) A certification by the buyer in the following form:

"The buyer is urged to carefully inspect the property and, if desired, to have the property inspected by an expert. The buyer understands that there are areas of the property for which the seller has no knowledge and that this disclosure statement does not encompass those areas. The buyer also acknowledges that the buyer has read and received a signed copy of this statement from the seller or seller's agent.

T3 .... (Date) .... (Seller)
T4 .... (Date) .... (Seller)"

(C) A statement concerning the responsibility of real estate brokers in the following form:

"This report in no way relieves a real estate broker of the broker's obligation under the provisions of section 20-328-5a of the Regulations of Connecticut State Agencies to disclose any material facts. Failure to do so could result in punitive action taken against the broker, such as fines, suspension or revocation of license."

(D) A statement that any representations made by the seller on the written residential disclosure report shall not constitute a warranty to the buyer.

(E) A statement that the written residential disclosure report is not a substitute for inspections, tests and other methods of determining the physical condition of property.

(F) Information concerning environmental matters such as lead, radon, subsurface sewage disposal, flood hazards and, if the residence is or will be served by well water, as defined in section 21a-150, the results of any water test performed for volatile organic compounds and such other topics as the Commissioner of Consumer Protection may determine would be of interest to a buyer.

(G) A statement that information concerning the residence address of a person convicted of a crime may be available from law enforcement agencies or the Department of Public Safety and that the Department of Public Safety maintains a site on the Internet listing information about the residence address of persons required to register under section 54-251, 54-252, 54-253 or 54-254, who have so registered.

(e) On or after January 1, 1996, the Commissioner of Consumer Protection shall make available the residential disclosure report prescribed in accordance with the provisions of this section and

sections 20-327c to 20-327e, inclusive, to the Division of Real Estate, all municipal town clerks, the Connecticut Association of Realtors, Inc., and any other person or institution that the commissioner believes would aid in the dissemination and distribution of such form. The commissioner shall also cause information concerning such form and the completion of such form to be disseminated in a manner best calculated, in the commissioner's judgment, to reach members of the public, attorneys and real estate licensees.

Sec. 52. Section 29-152n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Any person who violates any provision of sections 29-152e to 29-152m, inclusive, **[**and 38a-660a**]** shall be guilty of a class D felony.

Sec. 53. Subsection (f) of section 42-103jj of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) In lieu of physically providing the items listed in subsection (e) of this section, a developer filing an abbreviated application may provide a statement or statements certifying that any or all of the items required by subsection (e) of this section are available to be viewed electronically, at no cost to the department, through an electronic registry, web site or other electronic means approved by the commissioner. The method for accessing **[**said**]** such items shall be clearly disclosed in each such certification.

Sec. 54. Subsection (a) of section 42-103kk of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The commissioner may adopt regulations, in accordance with chapter 54, and prescribe and publish forms necessary to carry out the provisions of sections 42-103cc to 42-103ddd, inclusive. **[**The**]** If, after notice and hearing, the commissioner determines that a developer or person subject to sections 42-103cc to 42-103ddd, inclusive, has

materially violated any provision of sections 42-103cc to 42-103ddd, inclusive, or chapter 735a, the commissioner may (1) suspend or revoke the registration of, place on probation **[**,**]** or reprimand any person subject to sections 42-103cc to 42-103ddd, inclusive, (2) impose a civil penalty of not more than five thousand dollars for each violation of sections 42-103cc to 42-103ddd, inclusive, or (3) take any other disciplinary action authorized by sections 42-103cc to 42-103ddd, inclusive. **[**, if, after notice and hearing, the commissioner determines that a developer or person subject to sections 42-103cc to 42-103ddd, inclusive, has materially violated any provision of sections 42-103cc to 42-103ddd, inclusive, or chapter 735a.**]** Nothing in sections 42-103cc to 42-103ddd, inclusive, shall be construed to limit or deny any rights or remedies provided by law.

Sec. 55. Subdivision (16) of subsection (b) of section 42-103mm of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(16) A description of any bankruptcy of the developer that is pending or that has occurred within the past five years, pending civil or criminal suit, adjudication or disciplinary actions material to the time share plan of which the developer has knowledge;

Sec. 56. Subdivision (25) of subsection (d) of section 42-103mm of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(25) A description of the cancellation provisions and the waiver prohibition set forth in subsections (a) to (c), inclusive, of section 42-103pp;

Sec. 57. Subdivision (1) of subsection (c) of section 42-103uu of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) An institutional lender to a developer, for **[**so**]** as long as such lender holds a mortgage encumbering any interest in or lien against a

portion of the time share property; or

Sec. 58. Section 42-500 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage, and applicable to commercial leases entered, renewed, modified or extended on or after the effective date of this section*):

(a) If any insurance is required to be obtained for a lease pursuant to subsection (e) of section 42a-2A-305, any such agreement as set forth in said subsection shall disclose in a conspicuous manner: (1) Whether the insurance is included in the lease for no additional charge; (2) if the insurance is not included in the lease or if there is an additional charge for obtaining insurance through the lessor, that the lessee may purchase the required insurance from an insurer of the lessee's choice, subject to the lessor's right to reject that insurer for reasonable cause; and (3) that the insurance policies offered by the lessor may duplicate coverage already provided by a lessee's personal insurance policies.

(b) If insurance on the leased goods is neither required nor provided in such lease or by agreement, the lease **[**must**]** shall contain or be accompanied by a conspicuous statement in a record substantially as follows: "No insurance coverage for the leased goods, or loss of the leased goods, is provided under this lease.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-9(b)(2)
Sec. 2	*from passage*	38a-25(a)(15)
Sec. 3	*from passage*	38a-55(b)(3)
Sec. 4	*from passage*	38a-60(c)
Sec. 5	*from passage*	38a-91ff(d)
Sec. 6	*from passage*	38a-91k
Sec. 7	*from passage*	38a-102(d)
Sec. 8	*from passage*	38a-307a
Sec. 9	*from passage*	38a-336(a)(2)
Sec. 10	*from passage*	38a-352
Sec. 11	*from passage*	38a-433(a)

Sec. 12	*from passage*	38a-439(e)
Sec. 13	*from passage*	38a-465a
Sec. 14	*from passage*	38a-465c(a)
Sec. 15	*from passage*	38a-465g
Sec. 16	*from passage*	38a-478c(a)(1)
Sec. 17	*from passage*	38a-479rr(b)
Sec. 18	*from passage*	38a-481(b)
Sec. 19	*from passage*	38a-483(b)(6)
Sec. 20	*January 1, 2011*	38a-491a
Sec. 21	*January 1, 2011*	38a-492j
Sec. 22	*from passage*	38a-495a(f)
Sec. 23	*January 1, 2011*	38a-500(a)
Sec. 24	*January 1, 2011*	38a-504
Sec. 25	*from passage*	38a-511(c)
Sec. 26	*from passage*	38a-513e
Sec. 27	*January 1, 2011*	38a-517a(a)
Sec. 28	*January 1, 2011*	38a-518j
Sec. 29	*January 1, 2011*	38a-527(a)
Sec. 30	*from passage*	38a-538
Sec. 31	*January 1, 2011*	38a-542
Sec. 32	*January 1, 2011*	38a-546(a)
Sec. 33	*from passage*	38a-556
Sec. 34	*from passage*	38a-564(3) and (4)
Sec. 35	*from passage*	38a-569
Sec. 36	*from passage*	38a-760a(7)
Sec. 37	*from passage*	38a-790(d)(2)
Sec. 38	*from passage*	38a-839
Sec. 39	*from passage*	38a-840
Sec. 40	*from passage*	38a-841
Sec. 41	*from passage*	38a-842
Sec. 42	*from passage*	38a-843
Sec. 43	*from passage*	38a-844
Sec. 44	*from passage*	38a-845
Sec. 45	*from passage*	38a-916(a)
Sec. 46	*from passage*	38a-923(a)
Sec. 47	*from passage*	38a-962h
Sec. 48	*from passage*	14-64
Sec. 49	*from passage*	14-65g(a)
Sec. 50	*from passage*	14-65k
Sec. 51	*from passage*	20-327b

Sec. 52	*from passage*	29-152n
Sec. 53	*from passage*	42-103jj(f)
Sec. 54	*from passage*	42-103kk(a)
Sec. 55	*from passage*	42-103mm(b)(16)
Sec. 56	*from passage*	42-103mm(d)(25)
Sec. 57	*from passage*	42-103uu(c)(1)
Sec. 58	*from passage, and applicable to commercial leases entered, renewed, modified or extended on or after the effective date of this section*	42-500

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 11 $	FY 12 $
Department of Motor Vehicles	TF - Revenue Gain	Potential Minimal	Potential Minimal
Secretary of the State	GF - Revenue Gain	less than 1,200	less than 1,200

Note: TF=Transportation Fund; GF=General Fund

Municipal Impact: None

Explanation

There is a potential revenue gain to the Transportation Fund of up to $1,000 due to the expansion of penalties assessed by the Department of Motor Vehicles (DMV) to include violations of motor vehicle shop requirements. The amount of revenue gain will depend on the number of violations.

The bill also requires captive insurers, formed as a reciprocal insurer or limited liability company, to file articles of incorporation with the Secretary of State (SOS). These insurers would incur a one-time filing fee of $120. It is estimated that a maximum of ten such insurers will file in FY 11 and FY 12, for a maximum revenue gain to the General Fund of $1,200 in each fiscal year.

Other provisions of the bill are technical and clarifying changes and do not result in a fiscal impact to the state or municipalities.

House "A" eliminates a section of the underlying bill that makes technical changes to an existing statute, does not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. The fiscal impact identified above for SOS would continue into the future subject to the number of captive insurance companies, formed as a reciprocal insurer or limited liability company, filing articles of incorporation with SOS.

OLR Bill Analysis

HB 5006 (as amended by House "A")*

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.

SUMMARY:

This bill makes changes in various insurance and transportation statutes. It:

1. broadens the applicability of several health insurance benefits;

2. specifies penalties for, and expands the Department of Motor Vehicles (DMV) commissioner's authority regarding, violations of the motor vehicle repair shop notice requirements;

3. makes the insurance commissioner the agent to receive legal service of process for captive insurance companies domiciled in Connecticut if a registered agent cannot be found with reasonable diligence at the registered office;

4. requires all Connecticut-domiciled captive insurers, not just those formed as a corporation, to file a certificate of general good and articles of incorporation, if applicable, with the secretary of the state;

5. requires captive insurers domiciled outside of Connecticut offering, renewing, or continuing insurance here to submit to the insurance commissioner certain financial statements, risk retention group examination reports, and, upon request, risk retention audits;

6. resolves a statutory conflict within the license expiration and

renewal requirements for life settlement producers and brokers; and

7. makes other minor, technical, and conforming changes.

*House Amendment "A" deletes technical changes.

EFFECTIVE DATE: Upon passage, except for the provisions extending the applicability of certain insurance benefit requirements and a technical change, which are effective January 1, 2011.

§§ 21-22, 24-25, 28-30, & 32-33 — HEALTH INSURANCE BENEFITS

The bill broadens the applicability of several health insurance benefits required by law, as described below. (Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

General Anesthesia Relating to Dental Services (§§ 21 & 28)

The bill requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 to cover medically necessary general anesthesia, nursing, and related hospital services provided to patients with (1) complex dental conditions that require procedures to be performed in a hospital or (2) developmental disabilities that place them at serious risk. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover these services.

Both the bill and current law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Ostomy Appliances and Supplies (§§ 22 & 29)

The bill requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 to cover medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and

protectors, up to $1,000 annually. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover ostomy-related supplies.

Both the bill and current law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Bodily Injury (§§ 24 & 30)

The bill prohibits individual and group health insurance policies continued in Connecticut on or after January 1, 2011 from excluding coverage for a bodily injury solely because it was caused by a work-related accident to a person who is not covered by the workers' compensation law. The law already applies to policies delivered, issued, amended, or renewed in Connecticut.

Both the bill and current law apply to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; (d) accident only coverage; and (e) hospital or medical services, including coverage under an HMO plan and (2) individual health insurance policies that provide limited benefit health coverage.

Treatment of Tumors and Leukemia and Related Benefits (§§ 25 & 32)

The bill requires individual and group health insurance policies renewed, amended, or continued in Connecticut on or after January 1, 2011 to provide certain benefits for the treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients. The law already requires policies issued or delivered in Connecticut to provide these benefits.

Coverage must be subject to the same terms and conditions applicable to other policy benefits. But the policy must provide at least a yearly benefit of $500 for the surgical removal of tumors; $500 for reconstructive surgery; $500 for outpatient chemotherapy; $350 for a

wig; and $300 for a nondental prosthesis, unless the prosthesis is due to the surgical removal of breasts because of tumors, in which case the yearly benefit must be at least $300 for each breast.

Both the bill and current law apply to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; and (d) hospital or medical services, including coverage under an HMO plan, and (2) individual health insurance policies that provide limited benefit health coverage.

Continuation of Coverage (§ 33)

The bill requires group health insurance policies amended in Connecticut on or after January 1, 2011, regardless of the number of insureds, to contain state continuation of coverage ("mini-COBRA") provisions. The law already requires policies delivered, issued, renewed, or continued in Connecticut to contain those provisions.

Both the bill and current law apply to group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) hospital confinement indemnity coverage; (d) major medical expenses; and (e) hospital or medical services, including coverage under an HMO plan

§§ 49-51 — MOTOR VEHICLE REPAIR SHOP NOTICE REQUIREMENT

The bill allows the DMV commissioner to impose penalties for violations of the motor vehicle repair shop notice requirements under PA 08-146 (see BACKGROUND). It authorizes the commissioner to suspend or revoke a repair shop's license, fine the shop up to $1,000 for each violation, or both. In addition to, or in lieu of these penalties, the commissioner may order the licensee to make restitution to an aggrieved customer. By law, the commissioner may impose these penalties for violations of other repair shop laws.

By law, a repair shop customer may waive, in writing, his or her right to a repair estimate. The bill prohibits a repair shop from using

waivers to evade its repair shop notice requirements. The law already prohibits waivers to evade duties under other repair shop laws.

The bill authorizes the DMV commissioner to conduct investigations and hearings regarding a repair shop's compliance with the notice requirements. He currently has this authority with respect to other motor vehicle dealer and repairer laws. The bill also allows the attorney general, at the commissioner's request, to seek a restraining order requiring a repair shop to cease violating PA 08-146, a power he has with respect to other repair shop laws.

§§ 2, 5, & 6 — CAPTIVE INSURERS

The bill names the insurance commissioner the agent to receive legal service of process for captive insurance companies domiciled in Connecticut if a registered agent cannot be found with reasonable diligence at the captive's registered office. By law, the commissioner is already the agent for captive insurers domiciled outside of Connecticut that do business here.

The bill requires a captive insurance company formed as a reciprocal insurer or limited liability company to give the secretary of the state, along with any required filing fee, a certificate of general good from the insurance commissioner and the insurer's articles of incorporation, if applicable. By law, a captive formed as a corporation must already do this.

The bill also makes technical and conforming changes in the captive laws.

§§ 14 & 16 — LIFE SETTLEMENT STATUTES

The bill resolves a statutory conflict within the license expiration and renewal requirements for life settlement producers and brokers. PA 08-175 both retained the former law's requirements and added new, conflicting ones. The bill retains the former law, specifying that provider and broker licenses expire on March 31 in each year, but may be renewed annually. If a provider or broker fails to pay the renewal

fee on time, the commissioner must revoke his or her license, unless he or she pays within five days after the commissioner sends a written notice of nonrenewal by first class mail after March 31.

The bill deletes the following provisions: (1) the term of a (a) producer license is equal to that of a domestic stock life insurance company (annual renewal) and (b) broker license is equal to that of an insurance producer (if an individual, renewal is every other year on the person's birth date, and if an entity, February 1 of even-numbered years) and (2) licenses must be renewed on their anniversary dates and that failure to pay the renewal fee by that date results in license expiration.

The bill deletes another confusing and apparently erroneous provision from PA 08-175. The provision specifies that if a broker verifies the existence of a life insurance policy, then a life settlement provider is deemed to have fulfilled the law's extensive disclosure requirements.

By law, a life settlement provider, within 20 days after a life insurance policy owner executes a life settlement contract, must give the insurer that issued the policy written notice that the policy has become subject to a life settlement contract. The bill requires the provider to send the notice with a copy of the insured's (1) required medical records release form and (2) application for the life settlement contract, instead of with optional disclosure documents.

§ 18 — MEDICAL DISCOUNT PLAN ORGANIZATION

The bill authorizes the insurance commissioner to adopt regulations to establish an electronic filing process, instead of an electronic filing and acknowledgement process, for a medical discount plan organization to follow when updating its filed list of Connecticut marketers operating under a different name from its own.

§ 27 — PREMIUM PAYMENTS FOR TERMINATED EMPLOYEES

PA 09-126 allows an employer, with certain exceptions, to elect to

stop paying group health insurance premiums for an employee and his or her dependents as of 72 hours after the employee quits or is terminated for any reason except layoff. The bill adds another exception: relocation or closing of a "covered establishment" (i.e., an industrial, commercial, or business facility that employs, or has employed in the preceding 12 months, 100 or more people).

The bill specifies that an employee's or dependent's right to continue coverage after a covered establishment relocates or closes is not affected by PA 09-126. By law, when a covered establishment relocates or closes, the employer must pay for continued insurance coverage for affected employees and dependents for 120 days or until the employee becomes eligible for other coverage (CGS § 31-51o).

§ 53 — NOTICE TO COURTS AND POLICE DEPARTMENTS

The bill eliminates the class D felony penalty for the insurance commissioner's failure to provide courts and police departments a list of surety bail bond agents or changes to the list.

BACKGROUND

Repair Shop Notice and Acknowledgment (PA 08-146 as amended by PA 09-237)

The law requires automobile physical damage appraisals or estimates written on an insurer's or a motor vehicle repair shop's behalf to include the following notice in at least 10-point boldface type: NOTICE: YOU HAVE THE RIGHT TO CHOOSE THE LICENSED REPAIR SHOP WHERE THE DAMAGE TO YOUR MOTOR VEHICLE WILL BE REPAIRED (CGS § 14-65*l*).

The law prohibits a motor vehicle repair shop from repairing a vehicle unless the claimant (i.e., person whose insured vehicle needs repairs) acknowledges in writing that he or she is aware of the right to have the vehicle repaired at a shop he or she chooses (CGS § 14-65f). The acknowledgement may be (1) included in the repair authorization, which a customer signs before repairs are made, or in a separate document and (2) faxed or e-mailed. The acknowledgement must

state: "I am aware of my right to choose the licensed repair shop where the motor vehicle will be repaired."

By law, a "motor vehicle repair shop" means a new car dealer, a used car dealer, a repairer, or a limited repairer (CGS § 14-65e). No one may operate such a shop without a DMV-issued new car dealer's, used car dealer's, repairer's, or limited repairer's license (CGS § 14-52).

Captive Insurance Company (PA 08-127)

Effective January 1, 2009, the law permits a captive insurance company to be licensed and domiciled in Connecticut to transact life insurance, annuity, health insurance, and commercial risk insurance business. A captive insurance company is, in its simplest form, an insurance company that is a wholly-owned subsidiary whose primary function is to insure all or part of the risks of its parent company.

The law enumerates requirements for a Connecticut-domiciled captive's formation, capital and surplus, local office presence, ability to meet policy obligations, payment of certain fees and premium taxes, and annual reporting, among other things.

A captive domiciled outside of Connecticut may conduct business in Connecticut, subject to conditions specified in federal and state laws.

A company's domicile is the jurisdiction under whose laws the company is organized and in which it has its principal place of business.

Related Bills

The Insurance and Real Estate Committee favorably reported HB 5009, which includes changes found in §§ 22, 25, 29, and 32 of this bill.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 17 Nay 0 (02/23/2010)

Transportation Committee

Joint Favorable
Yea 26 Nay 0 (03/29/2010)

Judiciary Committee

Joint Favorable
Yea 40 Nay 0 (04/07/2010)